Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
American Specialty Pharmacy

Respondent Name
LM Insurance Corp

MFDR Tracking Number
M4-15-2374-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
April 2, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement submitted

Amount in Dispute: $117.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The charge for Carisoprodol was denied according to requirements of Texas TAC 134.530 which requires preauthorization for drugs not included in the closed formulary. Below is the formulary and shows this drug is an "N" classified drug."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 22, 2015	Carisoprodol 350 mg	$117.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.530 sets out requirements for use of the closed formulary for claims subject to certified networks.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes;
    - 197 – Per TX Rule 134.600 Pre-auth is required.

Issues

1. Did the carrier support that denial reason?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed service as 197 – "Per TX Rule 134.600 Pre-Auth is required." 28 Texas Administrative Code §134.530 states in pertinent part, "(a) Applicability. The closed formulary applies to all drugs that are prescribed and dispensed for outpatient use for claims not subject to a certified network on or after September 1, 2011 when the date of injury occurred on or after September 1, 2011. (b) Preauthorization for claims subject to the Division's closed formulary. (1) Preauthorization is only required for: (A) drugs identified with a status of "N" in the current edition of the ODG Treatment in Workers' Comp (ODG) / Appendix A, ODG Workers' Compensation Drug Formulary, and any updates;" Review of the submitted medical claim finds;
    a. Appendix A, ODG Workers' Compensation Drug Formulary lists – "Carisoprodol – with a status of "N"
    b. State of Pharmacy Services / DWC066 (no prior authorization present)

   Prior authorization was required but not obtained. The Carrier's denial is supported.

2. As requirements of Pharmacy Rule 134.530 were not met, no additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 2, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.